[BRIEF REPORT]

Informed Consent and Competency: Doctor's Dilemma on the Consultation Liaison Service

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ABSTRACT

With the increase in morbidity in the mentally ill, we also see an increase in the number of consultation requests from the medical and surgical departments to the psychiatric consultation team. Beside the classic questions of managing depression, psychosis, or agitation, psychiatrists are facing questions regarding patient competency. This usually refers to the patient's ability to consent to or refuse medical treatment, to be discharged against medical advice, or the patient's capacity to live independently and manage his or her own finances. In this article, the principles of informed consent and decision-making capacity will be reviewed, as well as the legal cases pertaining to these issues. A brief review of the existing literature will be summarized.

DOCTOR'S DILEMMA

What consultation-liaison psychiatrist never had to assess a patient's competency? When a patient with a history of psychosis is refusing to be investigated for massive gastrointestinal bleeding because he does not want to drink the colonoscopy preparation, or another patient who was diagnosed with mild mental retardation is refusing amputation for a gangrenous leg, or a depressed patient with diabetes mellitus who has massive cellulitis is refusing oral medications of any kind, the psychiatrist may find himself in a difficult position. Is the patient with the history of psychosis refusing to drink the colonoscopy

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preparation for a psychotic reason or for an accepted reason? Can the patient with mild mental retardation understand that he has a life-threatening condition? Why would the depressed patient allow only intravenous medications and not oral medications or even food? Is she suicidal? These are only a few dilemmas a psychiatrist may face when assessing a patient's competency or capacity to make a medical decision.

During the recent years, the need for consultation liaison psychiatry has increased, probably due to shortened length of hospital stay and the increased complexity of the medical problems that mentally ill patients have.[1] The medical and surgical units of the hospitals often ask psychiatrists to assess competency in various patients. While competence is a legal term and can only be determined by the courts, psychiatrists can help the medical team (and/or the courts) in the evaluation process when determining the capacity of such individuals to act in the matter in question.

TABLE 1. Informed consent principles

INFORMED CONSENT PROCESS	Knowledge	• Proposed procedure with benefits and risks • Alternative treatments with benefits and risks • Outcome without treatment
	Voluntariness	• Coercion from the healthcare provider invalidates the informed consent • Pressure from family is acceptable
	Competence	Patient should understand information disclosed

WHY IS THE PHYSICIAN BEING ASKED TO ASSESS COMPENTENCY?

The reasons for assessing competency vary. Mainly, when the patient agrees with the primary team and goes along with the proposed treatment, the competency question is not raised. Only when the patient refuses treatment or wants to leave the hospital against medical advice (AMA) is the psychiatrist called in to assess competency. For example, at a major teaching hospital in Pennsylvania, 673 psychiatric consultations were performed over a period of nine months. Fifty consultations were requested to evaluate competency. The requests were mainly prompted by treatment refusal or disposition concerns.[1]

Another study looked at 90 requests to assess competency. These requests were mainly prompted by the patient's refusal to accept the physician's recommendations for treatment or because of the patient's disposition.[2] Half of the consults were requested to inquire about competency to return home and manage finances, a quarter about competency to provide informed consent, and the rest were requested to determine competency to refuse treatment. Competency was undetermined for 23 patients, 36 patients were found incompetent, and 33 were competent.

It is important for the primary team to clearly and correctly explain to the psychiatric team the entire clinical and social picture of a patient along with a clear and specific question. Weinstock and colleagues focused on consultations received by psychiatrists at a VA hospital over a period of six months.[3] There were 66 requests for consult, and less than half were appropriate and/or specific. Among these were requests to determine total incompetence when not appropriate or necessary or for a physical issue not a mental issue. The desire to transfer patient to psychiatry, not to determine competency, was the issue on a number of cases, as well as the request to place an uncooperative patient on an involuntary psychiatric hold when no psychiatric problem could be uncovered. As demonstrated by this study, the competency question can be confusing at first.[2] "Can you assess this patient's competency?" is the question asked, but no specific competence is mentioned. This is particularly important because an individual can be competent for certain issues and incompetent for others. For example, somebody can be competent to make a will, but incompetent to live independently.

The different diagnoses that can lead to a finding of incompetence vary from psychotic disorders to depressive disorders or cognitive impairment. Weinstock and colleagues published another study with the characteristics of the patients that were referred for competency to give informed consent for treatment in a VA hospital setting.[4] Over a six-month period, from a total of 374 psychiatric consultations, 30 consultation requests were to determine competency to consent to medical procedures. The main diagnoses were organic brain syndrome, schizophrenia, depression, personality disorder, or no diagnosis. From 30 consultations, only 10 patients were considered to be incompetent by the psychiatric team, all of them with organic brain syndrome. These consultation requests were generally made for patients who refused treatment; some of them changed their minds after psychiatric consultation and after clarification of the issues with the primary care team.

At another hospital, from 2423 referrals during a three-year period, 79 referrals asked for the evaluation of competency.[5] The issues were self-care, informed consent, and the desire to leave AMA. The majority of patients (78.5%) were diagnosed with an organic mental disorder (e.g., dementia [51.6%], delirium [43.5%]).

While early articles discuss the paucity of literature on the consensus about one's competency to give informed consent for medical procedures, it seems that clearer guidelines for psychiatrists who are asked to assess patient competency have emerged lately.[6] The physician's struggle with the question of competency was described in an article

by Mahler and Perry.[7] They also suggested recommendations following a model adopted by Roth and colleagues in 1977.[8]

To avoid a claim of malpractice, a patient should have informed consent or informed refusal. The first time that the informed consent issue was brought to the courts was in 1960 with the case of Natanson v. Klein.[9] This case established the reasonable practitioner standard (what a reasonable practitioner in the same jurisdiction would disclose to a patient). Canterbury v. Spence in 1972 established the reasonable patient standard (what a reasonable patient under similar circumstances would want to know).[10] Similarly, there is the informed refusal process, which is when a patient refuses proposed treatment or procedure while being fully aware of the consequences. The informed refusal was the underlying issue in Truman v. Thomas when a patient died as a result of cervical cancer.[11] Although her primary care doctor advised her to have yearly pap smears, the patient refused, not knowing of the consequences of refusing such a simple procedure since her doctor did not emphasize the risks of refusing it (Table 1).

There are certain principles that govern the competency to accept or refuse treatment. The patient should understand information given to him or her and manipulate it in a rational manner, as well as appreciate the situation and its likely consequences and to be able to express a choice. The factual understanding includes the understanding of the diagnosis, the proposed treatment with its risks and benefits, the alternative treatments, and the outcome without treatment. The factual understanding can be impaired in cases of low IQ, mental retardation, dementia, poor education, poor attention span, or aphasia. The appreciation is altered when there is denial, delusions, suicidality, or confabulation. Ambivalent patients or the ones that have communication difficulties may not be able to express a choice or preference for a certain treatment (Table 2).

Incompetence stems from mental illness that causes a defect in judgement that would affect the area in question, but the presence of a mental illness alone does not equal incompetence. Legal incompetence is task specific, it depends on the consequences, and it can fluctuate over time. It is also task specific and involves functional deficits; somebody may be competent for certain issues, but incompetent for others. For example somebody can be competent to make a will, but incompetent to consent to high risk surgery.

There are different standards for competency depending on the benefit/risk ratio of the proposed treatment. Logically, there is a strict standard for refusal of treatment that has a high benefit to risk ratio, while there is a lenient standard for accepting such a treatment. When the proposed treatment has a tight benefit to risk ratio, the standard for refusing the treatment is lenient while accepting it requires a strict standard. Similarly, the courts can ask for a stricter standard when life and death are in question. The US Supreme Court held in Cruzan v. Director, Missouri Department of Mental Health that a state can ask for clear and convincing evidence of somebody's wish to withdraw life support.[12]

TABLE 2. Decision-making capacity

ALTERED DECISION MAKING CAPACITY	Factual Understanding	Dementia, MR or low IQ, delirium, poor attention span
	Rationality	Rationally arrive to the expressed choice of treatment
	Insight and Appreciation	Denial, delusions, suicidality
	Expressing a Choice	Ambivalence

CASE EXAMPLE WRAP UP

The first patient described in this article had a history of psychosis and believed his gastrointestinal bleeding was provoked by the "clowns in my house" and he did not want to drink the colonoscopy preparation because it was "poisoned liquid since it gives me chills." He also stated "I cannot have cancer because the bleeding stopped." During consultation and assessment, the patient was able to sustain attention to listen to the description of the colonoscopy through simple language, he was able reproduce it after five minutes in a somewhat disorganized manner, but he only recalled a distorted version at the end of the interview. The evaluator determined the patient was too concrete to understand the risks of the procedures and was not competent (lacked the capacity) to give consent for the procedure.

REFERENCES

1. Umpathy U, Ramchandani D, Lamdan RM, et al. Competency evaluations on the consultation liaison service. *Psychosomatics* 1999;40:28–33.
2. Farnsworth MG. Competency evaluations in a general hospital. *Psychosomatics* 1990;31:60–6.
3. Weinstock R, Copelan R, Bagheri A. Physicians' confusion demonstrated by competency requests. *J Forensic Sci* 1985;30(1):37–43.
4. Weinstock R, Copelan R, Bagheri A. Competence to give informed consent for medical procedures. *Bull Am Acad Psychiatry Law* 1984;12(2): 117–25.
5. Golinger RC, Fedoroff JP. Characteristics of patients referred to psychiatrists for competency evaluations. *Psychosomatics* 1989;30(3):296–9.
6. Sherlock R. Competency to consent to medical care. *Gen Hosp Psychiatry* 1984;6:71–6.
7. Mahler J, Perry S. Assessing competency in the physically ill: Guidelines for psychiatric consultants. *Hosp Community Psychiatry* 1988;39:856–61.
8. Roth LH, Meisel A, Lidz CW. Tests of competency to consent to treatment. *Am J Psychiatry* 1977;134:279–84.
9. Natanson v. Klein (1960) 350 P.2d 1093.
10. Canterbury v. Spence (1972) 464 F.2d 772 .
11. Truman v. Thomas (1980) 611 P.2d 902.
12. Cruzan v. Director, Missouri Department of Mental Health (1990) 497 U.S. 261.